System Transformation Initiative

Puyallup Tribal Health Authority
Kwawachee Counseling Center
2209 East 32nd St.
Tacoma, Washington

MEETING NOTES

February 5, 2007

Present: Jennifer LaPointe, Puyallup Indian Health; Deb Sosa, A.I.H.C.; Helen C. Fenrich, Tulalip Tribes; Ric W. Armstrong, Quinault Indian Nation; Peter Selby, TriWest; Andy Toulon, Avreayl Jacobson, and Gaye Jensen, Mental Health Division; Doug North, Sharri Dempsey, and Carmelita Adkins, Indian Policy and Support Services; Maria Monroe-Devita, WIMERT; Paul Dziedzic, Facilitator

Meeting Purpose:

- To share with Tribes and Recognized American Indian Organizations (RAIOs) the content & scope of the System Transformation Initiative (STI)
- To identify which STI projects the Tribes and RAIOs are interested in
- To identify process options for inclusion of Tribes' and RAIOs' concerns and input on projects of interest

These are comments from the conversation in reaction to the powerpoint presentation:

Background Slides

- Utilization—what does that mean? Is it the place of residence, who pays? The Tribes mental health system is different from the MHD public mental health system. Tribes may serve members no matter where they live.

- The utilization numbers are misleading. Are kids included anywhere in the data?

- STI should look at the gaps identified by the Tribes who responded to the Mental Health Transformation Grant. In some cases there are not just gaps, there are NO BRIDGES!!

- You can't get in to the RSNs. In some places the RSNs won't come to the table. RSNs don't participate in regional Tribal meetings and it becomes a roadblock.

- Question: Do the consultants know that Tribal mental health system are fee for service and are very different from the State system?

- Utilization—Concerning foster children, approximately 25 Indian youth committed suicide last year. Something is WRONG. We want to see children addressed by the Project. CA doesn't pay and the RSN resists because of residency issues.

- Discrimination is still alive—just a different face.

- These "things" (projects within STI) won't help our people very much right now, but we are still interested in knowing what's going on and have concerns about all these issues.

- Request: make a plan to continue communication.

- There are lots of Native American foster kids out there that we cannot coordinate for. Native youth make up 45% of out of home placements.

- We're going to be seeing a lot more youth with mental illness: the "crack and meth effect".

- Question: How much monitoring of RSNs is there?
    - MHD is required to review utilization
    - There is a new compliance unit in MHD for RSN oversight.

- EQRO-tend not to look at the basics, such as, are people getting what they need? They are good at counting things.

- Question: Is Common Ground linked to the State's housing plan and Tribal housing?

- Question on the timeline and the box entitled "MHD Stamp of Approval". What this means is identifying and flushing out the options for future policy changes that MHD might wish to embrace. Other than PACT which has funds for implementation, other ideas arising from the studies will need to be funded by the Legislature.

- There has been a request from IPAC to the MHD Director to reinstate the monthly IPAC Tribal Mental Health Workgroup in February. This would be a good place to discuss these follow-up issues, e.g. STI. We would also recommend a Roundtable on the east side of the State. Tribes have jurisdiction over their youth.

ITA Slides

- A significant issue is Tribal access to state hospitals (or lack of access).

- Related Tribal Codes need to be acknowledged in statute.

- Tribal Courts are not included in SSSB 6793.

- The State recognizes Tribal Courts but the counties do not; its' not just a mental health issue but JRA as well.

- RSNs need to accept referrals (from Tribal professionals), i.e. credentials and Tribal Codes, rather than wasting resources starting over.

- Tribal codes and court orders are a huge issue.

- Snoqualmie Tribe is working on their own determination process for in-patient stays.

- NOTE: There is a high level of interest in ITA from the Tribes.

- Once a person is involuntarily committed into the state system, the Tribal Court no longer has jurisdiction, or can give input into the welfare of their member.

- Kids need help quickly, before they succeed at suicide. Going through the RSN system creates a culturally incompetent experience.

- Tribal programs keep people out of the RSNs (meaning there are no financial impacts), but they don't get rewarded financially by the State.

- An increasing number of Tribal children have been exposed to trauma, etc, leading to more foster placements. This is a big concern, including:
    - Disproportionality
    - Multiple traumas, including the historical trauma that has been past on for generations
    - Being caught between two systems
    - Limits on services and treatment for foster kids

- We need residential wrap-around services for kids more than involuntary beds.

- Too many kids are committing suicide and Tribes don't have the capacity and access to state resources to deal with it.

- Still need a "last resort" process, but do what we can to avoid ITA.

- State systems don't allow Tribes to participate in planning, treatment, etc. There is a disconnect between jurisdiction and responsibility.

- Seeing more partnering between the Tribes, for example, the Lummi Tribe has a program for co-occurring youth.

- Evidence-based practices? They are not normed for Native American youth. This is another place for discussion that the Tribes are frustrated.

- Sometimes we ask the wrong questions, for example, how many dollars went to PACT teams to keep Native Americans out of the state hospitals?

- You need to implement the DSHS Consultation and Communications Protocols concerning communication! If you do the communication first, then you are ready to do consultation.

- There was a request for Tribal Consultation and coupled with a question about the timeline, the June 07 "MHD Stamp of Approval, and the fact that we are just beginning to talk today.

- Tribes have never had what they needed in terms of mental health (services). It takes time and several meetings.

Mental Health Benefits Package Slides

- Inadequate funding from the Indian Health Services.

- Impossible to access culturally competent services through the RSNs. When defining cultural competence, you need to talk to the Tribes about what is culturally competent!

- Access to care:
    - Is the person culturally appropriately assessed:
    - Is the person culturally and appropriately served?

- Could rates for Tribes be impacted? (Slide # 33) Fee for service works better for the Tribes. Some RSNs pay their providers using fee for service. RSNs can subcontract with Tribes now, but don't.

- There are policy disconnects—MHD/RSNs can contract with licensed facilities, but Tribal programs aren't required to be licensed by the State, but instead meet "applicable standards". Also, Tribes have the right to license their staff.

- Question: What is Tri-West's experience with Tribes? They have worked with Tribes in the Southwest part of the country, for example, with the Pueblo Tribes.

- Would love to see a definition of "resilient/recovery-oriented" services for Tribes. What does that mean for Tribes in the State of Washington?

- Getting the person well? Spiritual healing seems to be lacking.

PACT Slides

- Since you are implementing through the RSNs, how will these teams be tied to Ethnic Minority Mental Health Specialists? Will PACT teams have the same requirements for cultural consultations as the RSN?

- I disagree with the process for identifying if you are a Native American Mental Health Specialist. There are people who say they are a Native American Mental Health Specialist, who have offended people here and the State has told us our staff aren't Native American Mental Health Specialists!

- Appears to be a lack of Tribal inclusion in implementation of PACT.

Utilization Review Slides

- We're talking about inpatient UR and state hospitals. Does this also include community hospitals?

- RSNS don't keep track of Tribal utilization very well.

- If you get appropriate care, you shouldn't be in there so long. Did person get what they needed?

- Tribes send members out of state. Do we know the frequency? Sometimes the community is too small for successful recovery.

- There is a lot of misdiagnosis of Native children. Are we really treating them in a way that will heal them?

Housing Slides

- Slide 43, Page 22: I would ask each of the 6 RSNs, how many Tribes they work with and what services they provide to them.

- The Housing Consultant should ask the Tribes what kind of services they get from the RSNs regarding housing.

- Technical assistance helps. The Tribes have the land, but need technical assistance about funding options and who can do what, etc.

- For the Tribes represented today, the STI projects were prioritized in the following order for discussion:

    1. Involuntary Treatment Act (ITA)
    2. Mental Health Benefit Package
    3. PACT
    4. Utilization Review (UR)
    5. Housing

Discussion of How to Proceed from Here:

- There was discussion about :
  - Sending out a summary of today's discussion with the materials presented
  - Could STI pay for travel for Tribes from the east side of the State?
  - Learn from the Mental Health Transformation Grant (about a process for gathering input).
  - Consider conference calls
  - When scheduling additional meetings, piggy-back onto other scheduled meetings where the people you want are likely to be

- The following four steps were discussed as a plan of how to proceed:

  1.) Communicate with Tribes using established protocol to explain the following three steps that were recommended by the attendees at the February 5th meeting
  2.) Create an opportunity for follow-up east and west focus groups to gather Tribal input. Ask which of the 5 initiatives would be of priority interest, also sharing the priority order for the February 5th Roundtable group. Send out information ahead of time.
  3.) Communicate regularly about the progress/process of STI, preferably through the Tribal Mental Health Workgroup which will meet monthly (if reinstated), and if that option is not available, the HRSA subgroup which meets quarterly. Quarterly written updates to IPAC would also be helpful.
  4.) Assess and identify the point at which the process needs to convert to "consultation".

- Andy offered to look into amending the Consultant's contract's to include working with the Tribes; however, he cautioned that amendments take time.

- Draft reports—need to ask for feedback using Tribal consultation before it becomes final. Andy offered a suggestion for STI to consider a separate chapter addressing Tribal issues and concerns in the reports that are due.

- The meeting notes will be reviewed by the Tribes represented in the room today and staff for corrections before sending out to all Tribes.